DOCUMENT RESUME

ED 176 181 CG 013 782

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TITLE Obstacles Affecting the Development of Behavioral Prevention.
PUB DATE 16 Jun 79
NOTE 8p.; Paper presented at the Annual Convention of the Association for Behavior Analysis: International Organization (5th, Dearborn, Michigan, June 16-19, 1979)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Behavioral Science Research; *Behavior Change; Controlled Environment; *Cost Effectiveness; Experimental Programs; Financial Policy; Grants; Human Services; *Mental Health Programs; *Prevention; *Research Design; Researchers

ABSTRACT

The involvement of behaviorists in primary prevention for mental health programs has been limited, to date. Using behavioral researchers offers several advantages, including the need to emphasize prediction and a priori control of maladaptive behavior, increased cost effectiveness, and increased monies for research. Common obstacles to the participation of behaviorists in prevention programming are showing program effectiveness and demonstrating the benefits which come to a client as a result of intervention. Also, problems appear to exist with the behavioral researcher's reliance on subject-specific experimental designs and variables, which differ from strategies commonly used in the prevention field. In order to incorporate behavioral research prevention, researchers would likely emphasize changing the response classes rather than individual behaviors, identifying and modifying variables responsible for these response classes, and treating the environment rather than the individual. (Author/PJC)

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ED176181

OBSTACLES AFFECTING THE DEVELOPMENT OF BEHAVIORAL PREVENTION

by

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presented at

The Fifth Annual Convention of

The Association for Behavior Analysis

June 16-19, 1979

Dearborn, Michigan

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U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

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The general topic of the paper that we are presenting today is that of primary prevention, and more specifically, the problems hindering the participation of behaviorists in this field. To begin, let us clear up some possible questions. First, one of the major premises of our paper is that behaviorists are not currently involved in prevention. Perhaps it is not really fair to say this with such generality, because in the past we have been involved in some prevention programming; examples are Achievement Place, the Learning Village and others. However, what we are speaking of are not isolated programs such as the ones mentioned above, but primary prevention as it relates to the mental health system. For example, in the Department of Mental Health in Michigan, there are several programs (14 to be exact) which utilize non-behavioral procedures in the purported prevention of serious disorder. This is a problem that we will talk about later.

Another question that may arise is what do we mean by prevention. In the early 60's, Caplan (1961) divided prevention into three types: primary, secondary, and tertiary. In general, these terms are analogous to the more common ones of prevention, treatment and rehabilitation respectively. Our paper deals specifically with primary prevention, and we define this as the reduction of the incidence of predictable behavioral disorder in the general population (as opposed to any one client population). Secondary and tertiary prevention are areas that behaviorists are already actively involved in and as such, we will exclude these from our definition.

Still another area that we need to address is the question of why behaviorists should get involved in prevention. There are several possible advantages of doing so. First, from a scientific point of view, the ultimate goal of applied behavior analysis is to be able to predict and control behavior.

Skinner repeatedly makes this point in many of his writings. For example, Skinner in Science and Human Behavior, says the following:

> "By predicting the occurance of an event, we are able to prepare for it. By arranging conditions in ways specified by laws of a system, we not only predict, we control; we 'cause' an event to occur or to assume certain characteristics" (Skinner, 1953, p. 14).

Obviously, prediction and control are the two most important aspects of prevention. Therefore, the goals of applied behavior analysis and prevention are in some sense the same.

Another advantage for behaviorists and others is that prevention is more cost-effective than treatment both in terms of money and human misery. Few would argue with the point that the costs of treatment in clinics and institutions is extreme, or that fostering productive lives is an important goal for those of us in the human services.

From a legal point of view, prevention is one of the five mandated services of all mental health systems in the various catchment areas across the country and therefore services will exist whether behaviorists are active in the field or not. As an aside, President Carter has recommended that at least 10% of all money alocated to mental health programs be used for prevention. Thus, in terms of grant monies, prevention may be a very viable endeavor in the next few years.

Now, assuming that we all know what prevention is and hopefully agree that we should be more involved in it, what factors are hindering us? One problem common to all researchers in prevention is that of showing program effectiveness. Maladaptive behaviors are not evident (observable) in populations targeted for prevention programs. Therefore, it is very difficult to determine if there will be a problem if an intervention is not used. It is just as difficult to demonstrate what benefits come to the client as a result of the intervention; if a prevention program is successful, no observable maladaptive behavior will

surface at some future time. An often-told parable may help to illustrate this point. "A story is told of a man who would go out every night and bow at the sun, each time muttering something to himself. Although his neighbors interpreted his behavior as "strange", no one questioned him about it because they thought he must have good reason for doing what he did. Finally, one of his neighbors mustered the courage to ask him why he did it. "To keep away the bengal tigers", he replied. "But there are no bengal tigers around here", said the neighbor. The man smiled, looked at him and chirped, "See it works".

For purposes of clarity, the problems facing researchers behavior analysts in prevention will be discussed in terms of two areas: generality of variables and generalization of effects. Currently, in attempting to change behavior, most behavior analysts identify functional relationships between manipulable variables and some behavior. While this certainly is desirable, the requirements of long-term effects in prevention programs provide an obstacle for this approach. Individual and specific behaviors may not be predictive of general maladaptive response patterns at a later time. In this case, we may need to identify response classes which form molar variables that can be changed in order to produce effects large enough to be functional months or years later. For example, we may have a response class called aggressive behavior, which itself is made up of many specific behaviors. If one wishes to prevent aggression he/she cannot do so by simply changing one or two specific behaviors. A whole class of responses must be changed under a variety of stimulus conditions. The specific behavior change is even less meaningful in prevention when one considers that the actual dependent behavior will not have an opportunity to occur for months or even years. For more information on this issue, we refer you to an article by J.R. Kantor called "An Analysis of the Experimental Analysis of Behavior" (Kantor, 1970).

In a similar vein, by identifying the variables affecting response classes, we would be able to move away from problem-oriented behavior analysis, which most of us are engaged in now, and deal more directly with controlling behavior. In other words, presently most behavior analysts work within a treatment model by working with single subjects, and specific problem behaviors (i.e. self abuse, Pica, smoking, weight control, etc.). By identifying the variables which lead to these behaviors, changes can be made which will prevent these problems from occuring.

Additionally, we have to move away from treating the individual, and focus on the natural environment. This last statement is one that probably every behaviorist would agree with, yet in practical terms, most of us do not do it. Holland (1978) describes this situation in the following way: "If the very theory on which behavior therapy is based is correct, then the solution to a behavioral problem cannot rest in the specially arranged contingencies of the clinic. The contingencies of the natural environment must be modified if the problem is to be corrected." Changing the environment also means that a large group of people would be effected, and in the long run would be much more cost-effective. Also, by changing behavior in this way, we could be more confident that the effects of the intervention would generalize, because the person's total environment is taken into consideration, and long lasting, since we would be making a somewhat permanent change, rather than short-term therapy.

In order to do what we are suggesting above, changes will also have to be made in our research methods. For example, the single subject design normally used by many of us may not be adequate here. In most prevention studies, we are dealing with a large number of people, and changes which must endure for many years. In this case, correlational studies, or group designs

may be more appropriate as far as showing functional control.

To summarize, prevention researchers would be likely to emphasis the following methods:

a) changing response classes rather than individual behaviors;

b) identification and modification of the variables responsible for these response classes, rather than the problems themselves;

c) treating the environment, rather than the individual;

d) having effects on large numbers of subjects, rather than individuals.

If behaviorists are to enter the prevention area, some compromise may have to be made to close the gap between the methods mentioned above, and the current applied behaviorist strategies. A failure to do so would mean that a large part of the mental health system in this country would not be effected by behavior analysts.

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